WEEKLY EPIDEMIOLOGY BULLETIN

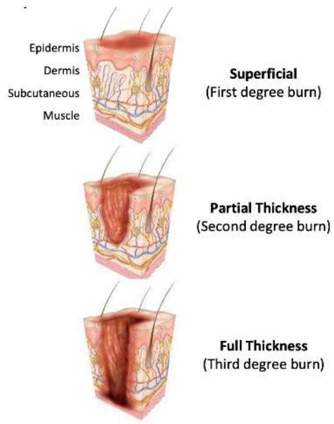
NATIONAL EPIDEMIOLOGY UNIT, MINISTRY OF HEALTH & WELLNESS, JAMAICA

-Burns-

A burn is an injury to the skin or other organic tissue primarily caused by heat or due to radiation, radioactivity, electricity, friction or contact with chemicals.

Thermal (heat) burns occur when some or all of the cells in the skin or other tissues are destroyed by:

- hot liquids (scalds)
- hot solids (contact burns), or
- flames (flame burns).



Key facts

•An estimated 180 000 deaths every year are caused by burns – the vast majority occur in low- and middle-income countries.

•Non-fatal burn injuries are a leading cause of morbidity.

•Burns occur mainly in the home and workplace.

•Burns are preventable.

First aid

Basic guidance on first aid for burns is provided below.

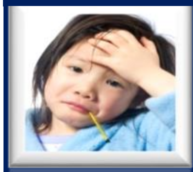
What to do

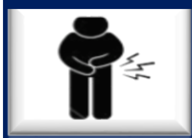
- Stop the burning process by removing clothing and irrigating the burns.
- Extinguish flames by allowing the patient to roll on the ground, or by applying a blanket, or by using water or other fire-extinguishing liquids.
- Use cool running water to reduce the temperature of the burn.
- In chemical burns, remove or dilute the chemical agent by irrigating with large volumes of water.
- Wrap the patient in a clean cloth or sheet and transport to the nearest appropriate facility for medical care.

What not to do

- Do not start first aid before ensuring your own safety (switch off electrical current, wear gloves for chemicals etc.)
- Do not apply paste, oil, haldi (turmeric) or raw cotton to the burn.
- Do not apply ice because it deepens the injury.
- Avoid prolonged cooling with water because it will lead to hypothermia.
- Do not open blisters until topical antimicrobials can be applied, such as by a health-care provider.
- Do not apply any material directly to the wound as it might become infected.
- Avoid application of topical medication until the patient has been placed under appropriate medical care.

EPI WEEK 47





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SENTINEL SYNDROMIC SURVEILLANCE

Sentinel Surveillance in Jamaica

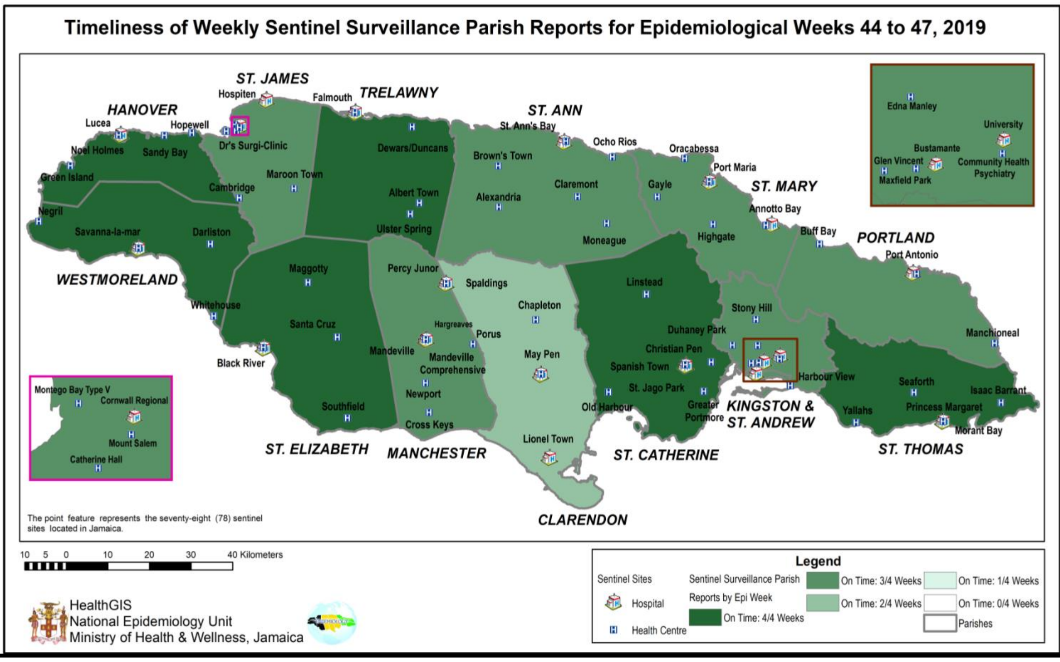
A syndromic surveillance system is good for early detection of and response to public health events.

Sentinel surveillance occurs when selected health facilities (sentinel sites) form a network that reports on certain health conditions on a regular basis, for example, weekly. Reporting is mandatory whether or not there are cases to report.

Jamaica's sentinel surveillance system concentrates on visits to sentinel sites for health events and syndromes of national importance which are reported weekly (see pages 2 -4). There are seventy-eight (78) reporting sentinel sites (hospitals and health centres) across Jamaica.

Map representing the Timeliness of Weekly Sentinel Surveillance Parish Reports for the Four Most Recent Epidemiological Weeks - Weeks 44 to 47

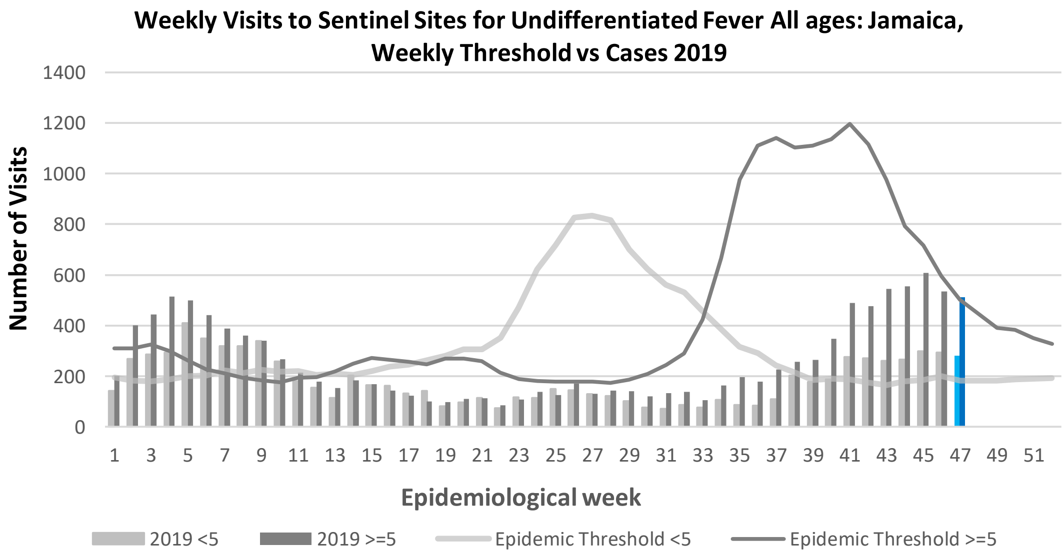
Parish health departments submit reports weekly by 3 p.m. on Tuesdays. Reports submitted after 3 p.m. are considered late.



REPORTS FOR SYNDROMIC SURVEILLANCE

FEVER

Temperature of >38⁰*C* /100.4⁰*F* (or recent history of fever) with or without an obvious diagnosis or focus of infection.



KEY

VARIATIONS OF BLUE SHOW CURRENT WEEK

2 NOTIFICATIONS- All clinical sites

INVESTIGATION REPORTS- Detailed Follow up for all Class One Events

HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued

SENTINEL REPORT- 78 sites. Automatic reporting

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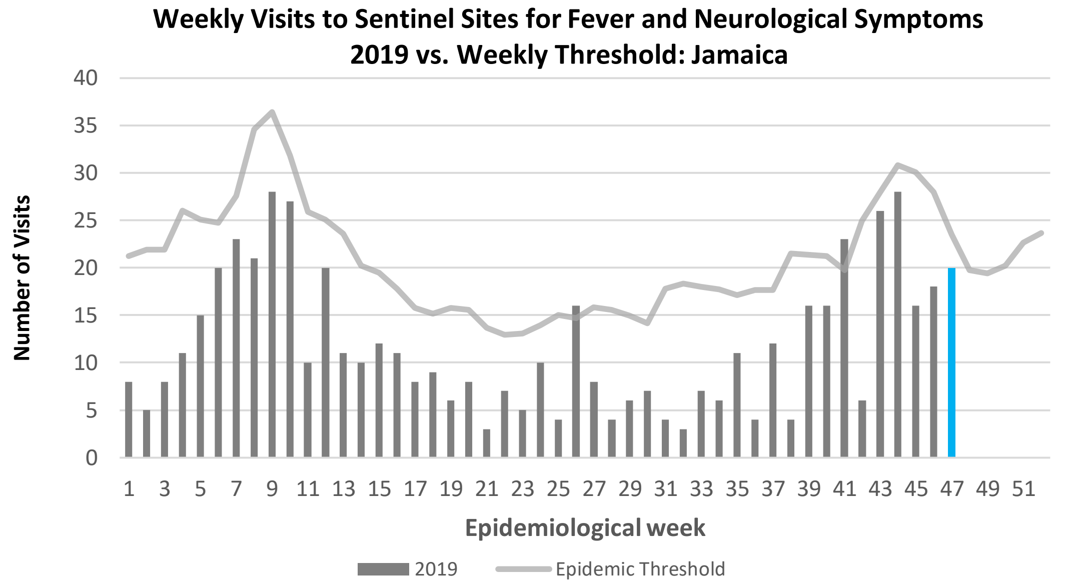
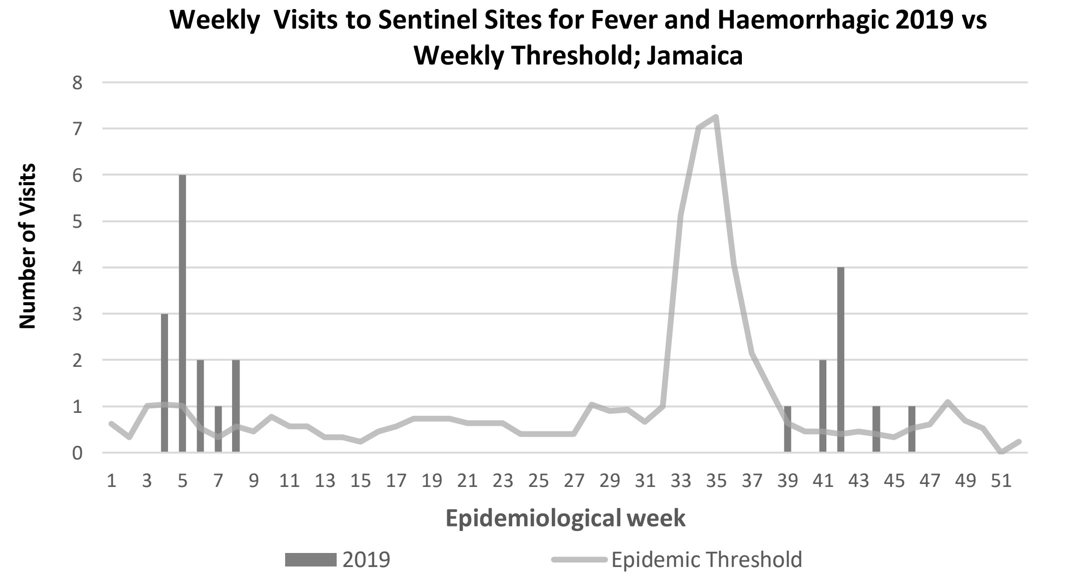
FEVER AND NEUROLOGICAL

Temperature of >38⁰C /100.4⁰F (or recent history of fever) in a previously healthy person with or without headache and vomiting. The person must also have meningeal irritation, convulsions, altered consciousness, altered sensory manifestations or paralysis (except AFP).



FEVER AND HAEMORRHAGIC

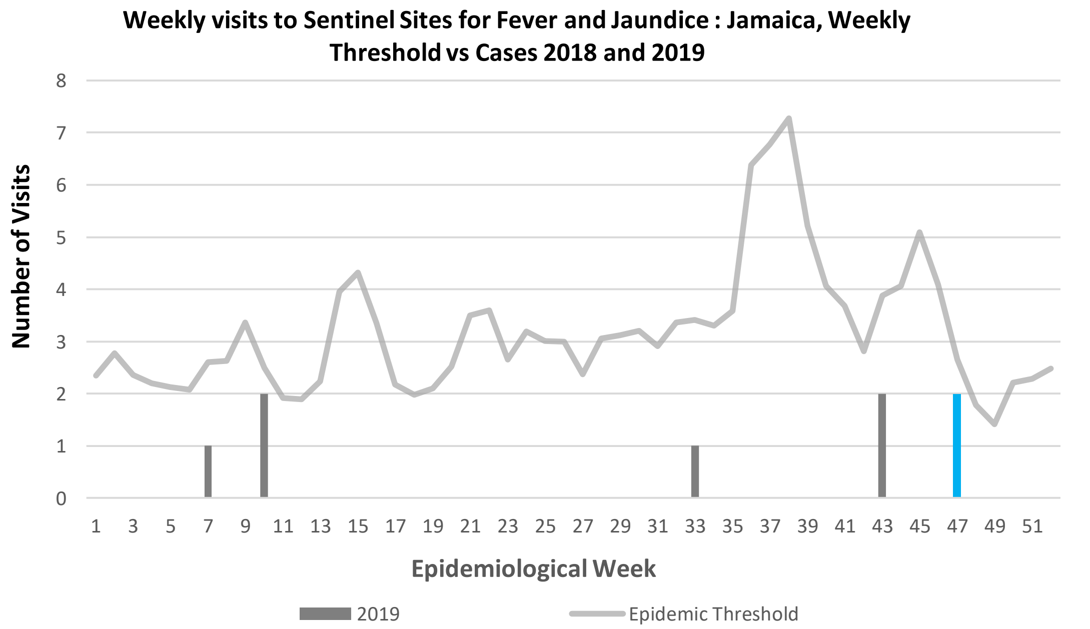
Temperature of >38⁰C /100.4⁰F (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice. Visits for Fever and Haemorrhagic symptoms were reported in weeks 4 to 8, 39,41,42, 44 and 46 year to date.



FEVER AND JAUNDICE

Temperature of >38⁰C /100.4⁰F (or recent history of fever) in a previously healthy person presenting with jaundice.

The epidemic threshold is used to confirm the emergence of an epidemic in order to implement control measures. It is calculated using the mean reported cases per week plus 2 standard deviations. Visits to sentinel sites for Fever and Jaundice were reported in weeks 7, 10, 33, 43 and 47 only, year to date.



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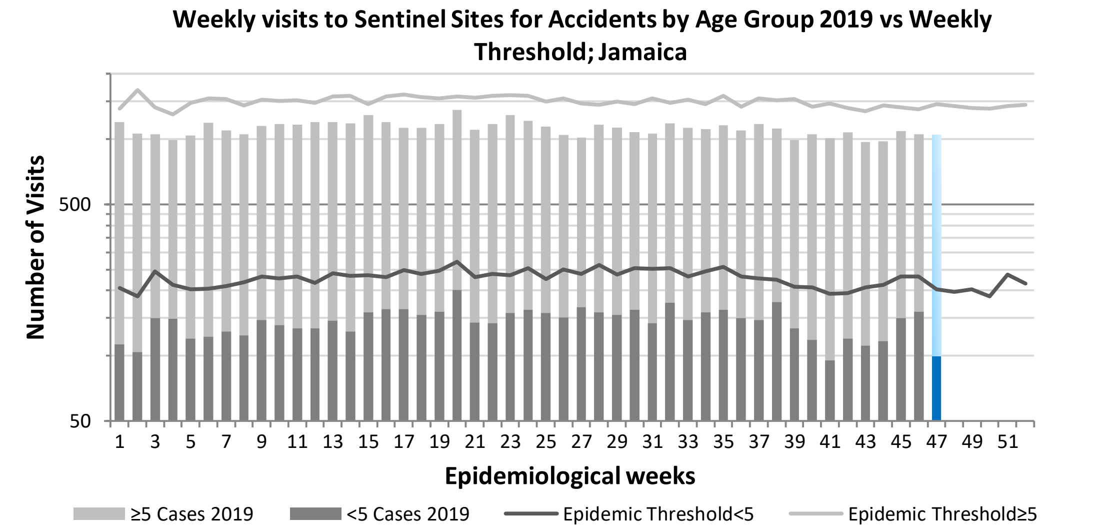
ACCIDENTS

Any injury for which the cause is unintentional, e.g. motor vehicle, falls, burns, etc.

KEY

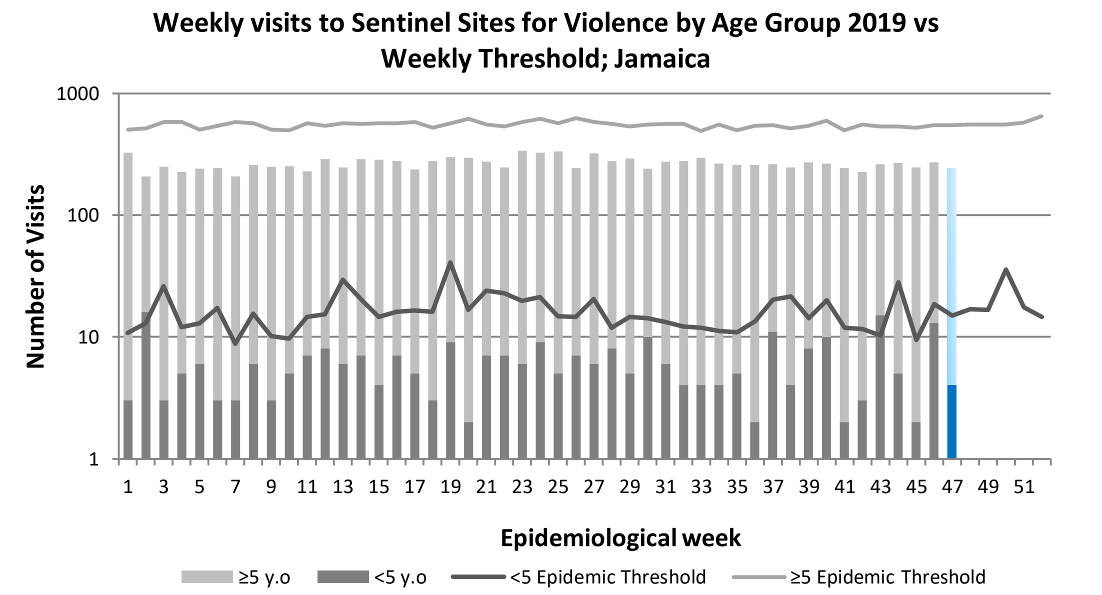
VARIATIONS Of BLUE SHOW CURRENT WEEK



Weekly visits to Sentinel Sites for Accidents by Age Group 2019 vs Weekly Threshold; Jamaica

VIOLENCE

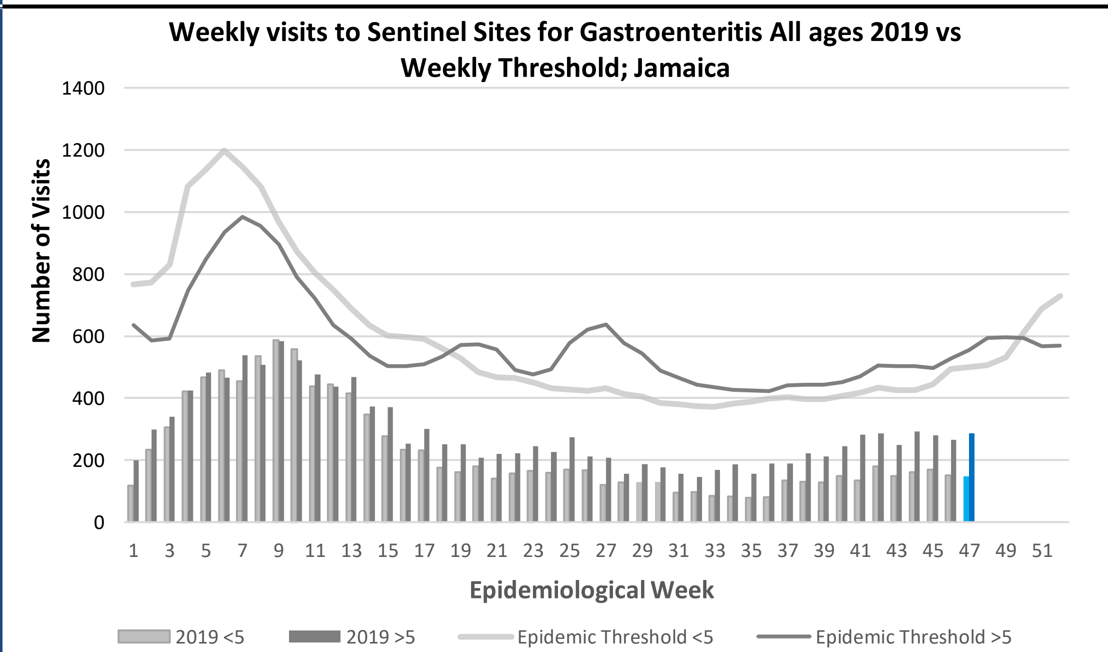
Any injury for which the cause is intentional, e.g. gunshot wounds, stab wounds, etc.



Weekly visits to Sentinel Sites for Violence by Age Group 2019 vs Weekly Threshold; Jamaica

GASTROENTERITIS

Inflammation of the stomach and intestines, typically resulting from bacterial toxins or viral infection and causing vomiting and diarrhoea.



Weekly visits to Sentinel Sites for Gastroenteritis All ages 2019 vs Weekly Threshold; Jamaica

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CLASS ONE NOTIFIABLE EVENTS Comments

	CLASS 1 EVENTS	Confirmed YTD CURRENT YEAR	Confirmed YTD PREVIOUS YEAR
NATIONAL /INTERNATIONAL INTEREST	Accidental Poisoning	64	177
	Cholera	0	0
	Dengue Hemorrhagic Fever*	NA	NA
	Hansen's Disease (Leprosy)	0	0
	Hepatitis B	23	85
	Hepatitis C	2	7
	HIV/AIDS	NA	NA
	Malaria (Imported)	0	5
	Meningitis (Clinically confirmed)	20	37
EXOTIC/ UNUSUAL	Plague	0	0
H IGH MORBIDIT/ MORTALIY	Meningococcal Meningitis	0	0
	Neonatal Tetanus	0	0
	Typhoid Fever	0	0
	Meningitis H/Flu	0	0
SPECIAL PROGRAMMES	AFP/Polio	0	0
	Congenital Rubella Syndrome	0	0
	Congenital Syphilis	0	0
	Fever and Rash – Measles	0	0
	Fever and Rash – Rubella	0	0
	Maternal Deaths**	55	59
	Ophthalmia Neonatorum	222	272
	Pertussis-like syndrome	0	0
	Rheumatic Fever	0	0
	Tetanus	0	0
	Tuberculosis	54	72
	Yellow Fever	0	0
	Chikungunya***	7	10
	Zika Virus****	0	1

AFP Field Guides from WHO indicate that for an effective surveillance system, detection rates for AFP should be 1/100,000 population under 15 years old (6 to 7) cases annually.

Pertussis-like syndrome and Tetanus are clinically confirmed classifications.

* Dengue Hemorrhagic Fever data include Dengue related deaths;

** Figures include all deaths associated with pregnancy reported for the period.

*** CHIKV IgM positive cases

**** Zika PCR positive cases

NA- Not Available

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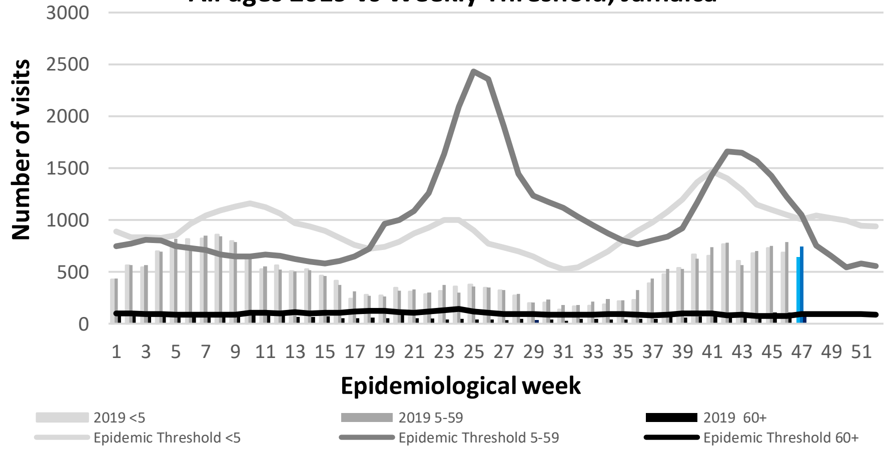
NATIONAL SURVEILLANCE UNIT INFLUENZA REPORT

EW 47

November 17– November 23, 2019 Epidemiological Week 47

	EW 47	YTD
SARI cases	9	483
Total Influenza positive Samples	12	458
Influenza A	12	415
H3N2	10	178
H1N1pdm09	0	226
Not subtyped	2	8
Influenza B	0	43
Parainfluenza	0	7

Weekly visits to Sentinel Sites for Influenza-like Illness (ILI) All ages 2019 vs Weekly Threshold; Jamaica

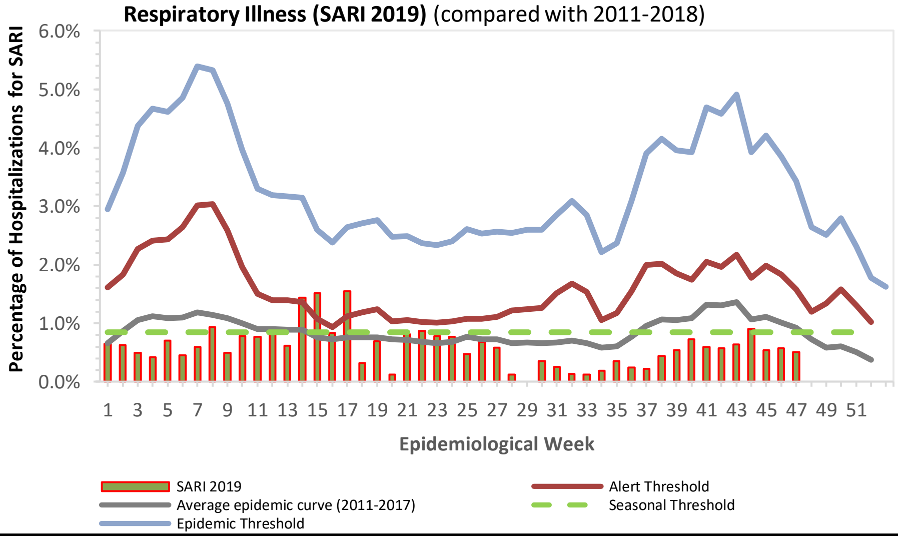


Epi Week Summary

During EW 47, 12 cases of influenza were detected. Percent positivity is 48% .

During EW 47, 9 (nine) SARI admissions were reported.

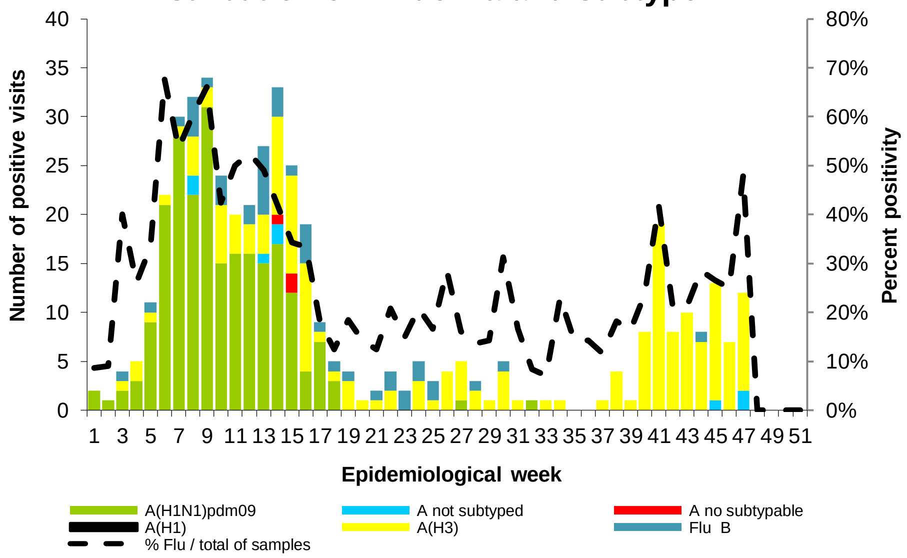
Jamaica: Percentage of Hospital Admissions for Severe Acute Respiratory Illness (SARI 2019) (compared with 2011-2018)



Caribbean Update EW 47

Overall, influenza and SARI activity continued at low levels with influenza A(H3N2), A(H1N1)pdm09, and influenza B viruses co-circulating in the subregion. In Jamaica influenza activity continued increased with influenza A(H3N2) virus predominance and SARI cases at low levels. In Trinidad and Tobago, after a peak in EW 45, influenza activity began to decrease with influenza A(H1N1)pdm09 predominance and A(H3N2) co-circulating; SARI activity decreased but remained above the epidemic threshold.

Distribution of influenza and subtype



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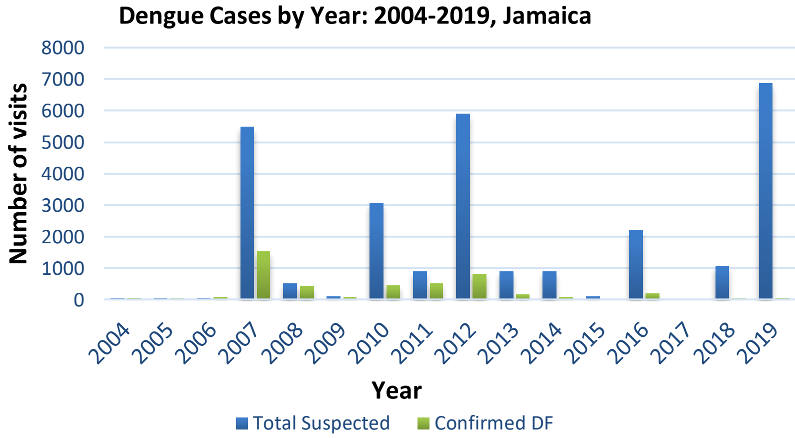
Dengue Bulletin

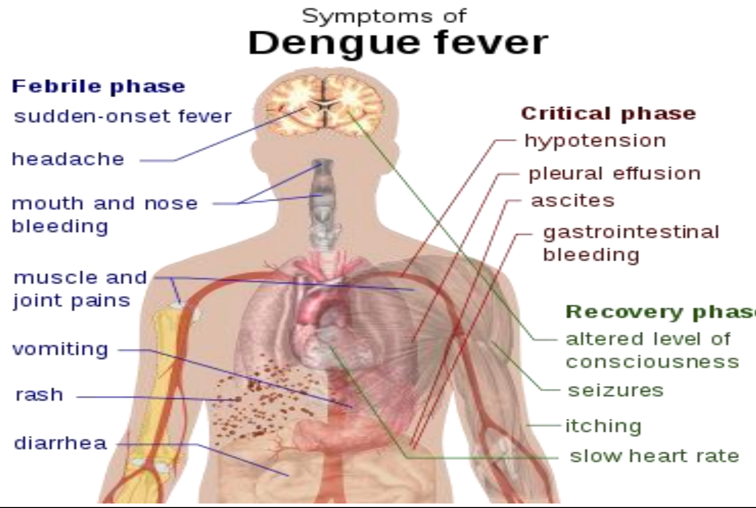
November 17 – November 23, 2019 Epidemiological Week 47

Epidemiological Week 47



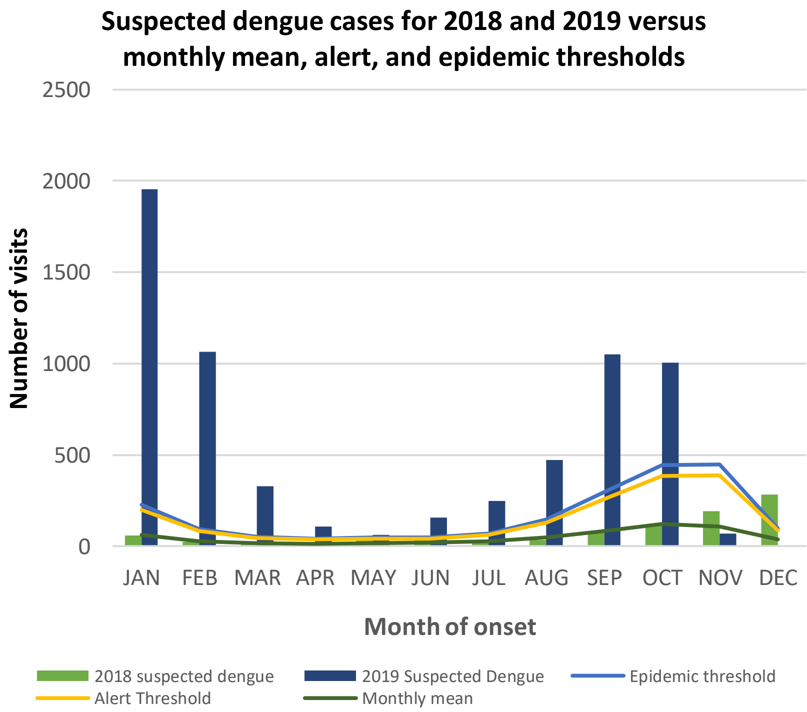
Reported suspected and confirmed dengue with symptom onset in weeks 1-47 2019

	2019		2018 YTD
	EW 47	YTD	
Total Suspected Dengue Cases	0	6882	570
Lab Confirmed Dengue cases	0	60	11
CONFIRMED Dengue Related Deaths	0	15	2



Points to note:

- ****figure as at November 28, 2019**
- **Only PCR positive dengue cases are reported as confirmed.**
- **IgM positive cases are classified as presumed dengue.**



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RESEARCH PAPER

ABSTRACT

Title:

Psychiatric Relapse and Hospital Readmissions:

A Qualitative Study to Explore the Perspectives of Persons Living with Serious Mental Illness in Western Jamaica

Author: Debra Roof, Department of Psychiatry, Cornwall Regional Hospital, Western Region Mental Health Services
Email: debbiroof@yahoo.co.uk

Theme: Chronic Non-communicable diseases (mental health)

Abstract:

Objectives: To conduct a qualitative study that explores patients' perspectives of the barriers and facilitators to recovery by:

Exploring accounts of what is helpful or unhelpful for persons in staying well and out of hospital through a set of face-to-face semi-structured interviews with a sample of outpatients frequently hospitalised.

Examining the overarching themes and shared experiences between patients by conducting a thematic analysis across the interview data.

Methods: A qualitative research methodology was used to investigate the perspectives of nine outpatients with a diagnosis of serious mental illness and frequent hospitalisation. Data collection was through face-to-face semi-structured interviews which explored the lived experience of staying well and out of hospital. Interviews were transcribed verbatim, data was manually coded and analysed using thematic analysis.

Findings: Six overarching themes: unmet basic needs, stopping medication, stress, marijuana use, influences of other people and physical effects were identified for the barriers to recovery. Five overarching themes: obtaining basic needs, taking medication, occupation, faith and the therapeutic aspect of the ward were the facilitators to recovery.

Conclusions: For this psychiatric setting there needs to be more concerted efforts to develop outpatient follow-up with psychosocial programmes that enhance rehabilitation and integrated care continuum for persons with mental illness. The importance of this study is that it provides a platform for patients living in Western Jamaica and gives insights into the lived experience. This has implications for therapists by building local knowledge and links to evidence-based practices that can improve patients' treatment and recovery outcomes.